Katie Beckett Unit
Executive Office of Health and Human Services
Hazard Building (Bldg 074) – 74 West Road, Ground Level
Cranston, R.I. 02920

INSTRUCTIONS FOR COMPLETION OF 3 BANK ACCOUNT VERIFICATION FORMS KB DHS AP-91 FOR A CHILD WHO IS APPLYING FOR KATIE BECKETT AND FOR ANNUAL REDETERMINATION

The Executive Office of Health and Human Services (EOHHS) policy requires that the three (3) attached bank account verification forms (KB EOHHS AP-91) be signed by a parent, legal guardian or adult representative of a minor child and returned to EOHHS for bank verification.

EOHHS will manage the bank verification process, so parents don't need to do anything other than enter the child's information and sign these forms.

All three forms must be signed and returned, even if the child does not have a bank account.

Purpose: These forms are used to verify accounts in the child's name and owned by the child. The Katie Beckett Unit will then mail these completed forms to three different, selected banks. Each bank will verify the presence or absence of an account in the child's name and social security number and return the bank account verification to the Katie Beckett Unit.

Parents and guardians should not provide their financial or bank account information.

If additional information is required for the completion of these forms, please contact your Social Caseworker:

If your child's last name begins with **A – M**, call Caridad Ramos at (401) 462-0760.
If your child's last name begins with **N – Z,** call Ann Murphy at (401) 462-0754.

Thank you!

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Authorization of Release of Financial Account Information - Katie Beckett Unit

his is an authorization for release of account information to the Executive Office of Health and Human Services for the minor child identified below. The information is needed only on those accounts for which the child is an owner of an account either singly or jointly with another individual(s). The child's parent, legal guardian or legal representative must sign and return this authorization to **EOHHS Katie Beckett Unit**, which will then mail to three selected financial institutions. Thank you.

_____

Child's Last Name **First Name** **MI**

_____

Address Street **City** **State** **Zip code**

_____ _____ _____

Birth date **Birthplace** **Social Security Number**

I, _____, parent/guardian/legal representative of minor child,
(**Print Parent's/Legal Guardian's Name**)
_____, hereby authorize the release of all bank information
(Print Minor Child's Name)
required to determine this child's eligibility for RI Medical Assistance. I understand that this bank information is confidential and is to be used only for determining eligibility for benefits.

_____ _____

(Signature of Parent/Legal Guardian/ Legal Representative of minor child) **(Date)**

TO: SELECTED BANK - MAIN OFFICE:	FROM and RETURN TO: EOHHS – Center for Child and Family Health Katie Beckett Unit Hazard Building 74 West Road, Ground Level Cranston RI 02920

(BANK REPORT to be completed, signed below by Bank Representative and returned to EOHHS)

___ **No Record of Account**

___ **Open Account:**

Checking Account (s) Account #_____
Current Balance $_____ Date Opened_____
Current Balance $_____ Date Opened_____

Savings Account (s) Account #_____
Current Balance $_____ Date Opened_____
Current Balance $_____ Date Opened_____

___ **Other Asset Account (s): Account #: _____**
Type of Account _____ Current Balance $_____ Date Opened_____
Type of Account _____ Current Balance $_____ Date Opened_____

___ **Closed Account Within Past 60 Months:**
Type of Account_____ Date Opened _____ Date Closed_____
Type of Account_____ Date Opened _____ Date Closed_____

___ **Safe Deposit Box:** _____ Yes ____ No Record

Signed: _____ _____ _____
Bank Representative Print Name Date

KB-EOHHS-AP-91 Rev. 1/14

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